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¶1. Post appreciates the opportunity to comment on goals and principles of President Obama?s Global Health Initiative. As stated, individual government agencies involved in defining practices, implementation, and governance have been actively involved in discussions (e.g. HHS/CDC, USAID, STATE), and have engaged with the field. Note: Post was visited by S/GAC?s A. Gavaghan on November 10, 2009; she facilitated a GHI Listening Session where inputs from all agencies were solicited.

¶2. Kenya currently has the largest USG health portfolio globally (approximately $600 million/year), with major financial support from PEPFAR and the President?s Malaria Initiative (PMI). USG health programs in Kenya are implemented by four agencies: USAID, HHS/CDC, USAMRU, and the US Peace Corps. Beyond HIV and malaria interventions, USAID also is authorized to provide technical and financial support for family planning, maternal/child health, and tuberculosis. Both HHS/CDC and USAMRU provide substantial support for public health research, surveillance, and national surveys, and both have substantial research capacity through large field sites. HHS/CDC research focuses on malaria, HIV/AIDS, and emerging infectious diseases, and its programmatic work also extends to outbreak investigations, refugee health, and influenza in a strong partnership with the Ministries of Health. The robust combined USG bilateral program aims to improve specific health outcomes, and to build capacity of the host country to assume key functions while promoting an increase to the GOK budget line item for health.

¶3. The principles of GHI ? a women-centered approach, strategic integration, leverage multi-lateral institutions, country ownership, sustainability, improve M&E, promote research development and innovation ? exist now in Kenya as pillars of the current program. For this reason, much attention has been given to the health program in Kenya. Specifically, integration of vertical disease interventions has resulted in comprehensive, ?horizontal? services delivered as a package to clients. An example of a best practice, USAID has ?blended? resources resulting in substantial health improvements in technical areas receiving relatively small funding (e.g. child health). 2008/09 Demographic and Health Survey (DHS) saw a welcome drop in the under five mortality rate from 114 to 74, thanks in large part to increased use of malaria bednets and childhood immunizations. Integrated or ?wrap around? programs have been implemented in Kenya at large scales, with wide-spread HIV counseling and testing services also reaching family planning needs of all clients. Some implementing partners are conducting door-to-door HIV testing, bringing a key package of health services into the privacy of one?s home. Historically, Kenya has embraced the GHI principle of integration and

demonstrated measurable results from this strategic approach.

¶4. USG agencies have also been keenly aware of development issues related to sustainability. Programming over $.5billion annually, USG is challenged to continue achieving great success while moving the country towards more sustainable health services. Capacity building, in the form of provider training, has helped produce a cadre of skilled health workers. Training in basic management and leadership skills is greatly improving the country?s ability to manage and supervise programs in the public and private sectors. HHS/CDC supports a Field Epidemiology and Laboratory Training Program that has greatly enhanced indigenous capacity for outbreak response and surveillance, and USG-supported research has contributed to dozens of Kenyan scientists obtaining higher degrees. Institutional capacity building in Kenya has allowed for some young NGOs to grow and mature, becoming eligible to raise funds and manage health programming at a standard respected by the international community. While sustainability challenges are great, Kenya is maximizing efforts to build the capacity of both individuals and institutions for long term health sector improvements.

¶5. The Kenya program places the client at the center of all health interventions. While this has proven to help bring comprehensive services to mothers, children

and their families, recent data has suggested that more could be done to focus on the health of mothers. Specifically, 2008/9 DHS data demonstrate that while major improvements are happening elsewhere in the country, maternal mortality is on the rise. This has produced a national response, calling for greater emphasis on women as targets of primary health care. Safe motherhood programs will need to be expanded into rural regions to help reduce the risks associated with pregnancy and delivery. Such programs should be integrated with current and future efforts to prevent mother-to-child transmission of HIV. In keeping with the GHI women-centered principle, Kenya programs will re-commit to investing in life-saving interventions that impact mothers and their newborns.

¶6. Other opportunities relevant to GHI include the principle of country ownership. Large health portfolios, like that in Kenya, must face country ownership as an element of sustainability. GHI will need to emphasize GOK institutions ? Ministries, Universities, Regulatory Bodies and others, ? in addition to continuing support civil society and public-private partnerships. Benchmarking of proxy indicators among host country governments will become increasingly important as part of the development assistance program. For example, countries like Kenya could be encouraged to build annual increases into budget line items (e.g. anti retroviral procurement) with the aim of eventually supporting the majority of HIV patient drug needs. Similarly, support for expanding access to social health insurance for the poor will remove financial barriers to care. Research around market segmentation or private sector analysis of client preferences can help shift paying clients to private services and reduce the burden now placed on public facilities. All of these proposed finance schemes reflect the need to shift ownership from international donors to the host country.

¶7. As expressed during the November Listening Session, USG agencies were unified in their belief that labor-intensive reporting requirements need to be better balanced against time needed to oversee the design, implementation, monitoring, and evaluation of on-going activities. PEPFAR has not benefited as much as it could have from operational research and the processes

for learning quickly from implementation experience will have to be made simpler than the currently cumbersome Public Health Evaluation system.

¶8. In sum, Kenya?s large health program already aims to meet many of the GHI goals and principles. With multiple USG agencies engaged in Kenya, in-country governance structures are well-established at both the policy and project levels (for HIV and malaria). New structures might duplicate already highly functioning systems in countries where the health portfolio is stable, and mature. Overall, GHI principles are firmly reflected in Kenya?s strong bilateral health program.
RANNEBERGER